



Integrated Care Communities

The needs of the people of West, North and East Cumbria are changing with a growing elderly population. Health and social care services therefore also need to adapt to improve people's experience of services and to continue to meet the needs of local people.

NHS Organisations in West, North and East Cumbria and Adult Social Care are currently working up a detailed plan of how best to integrate services across the patch and have begun to implement this in a number of ways. Integrated Care Communities (ICCs) are one of the key developments that will help improve the care we provide to the population.

The programme of work described here as Integrated Care Communities is part of a wider whole systems review of how health and care services are delivered. The development of integrated care nearer to home will be most effective if it is done alongside:

- The development of system wide care pathways for key conditions and needs such as Stroke, Frailty, end of life and Respiratory illnesses
- Integrated work to improve health and well-being and prevent ill health, dealing with lifestyles and social and economic challenges
- A new model of integrated services for professionals working in and around acute hospitals to reduce admissions and lengths of stay and return people home as soon as possible
- New models of support commissioned by the NHS and Councils working together to invest in Extra Care Housing, high quality dementia and nursing care, assistive technologies and support from the community sector .Investment in digital solutions to support self-help, telecare and telemedicine and improve choice and control for the public
- New approaches to co-production of services with individuals, families and communities to achieve a truly fully engaged community
- The sharing of learning across sectors as well as the integrating of pathways, for example, the experience of Direct Payments in the Council can help develop Direct Payments for Health Services while the experience of risk stratification in the NHS may help the Council improve its 'case spotting capability'.

1. Improving health & care services for West, North & East Cumbria people

Health services provided by the different parts of the NHS and the range of agencies involved in Social Care do not always join up in the way that patients and service users need and expect them to. Individually, health and social care services are doing a good job, but West, North and East Cumbria people's experience of the system as a whole is often confusing and disjointed.

For example, a patient needing NHS district nursing support as well as social care support with eating or dressing may need to see many professionals from different organisations, each conducting a separate assessment and asking the same or similar questions before support can be put in place. This can be frustrating and upsetting for patients and service users who find it difficult to understand why services don't communicate better with each other.

With the current system, local people sometimes spend longer in hospital than they need to because there is a delay in co-ordinating services to support them at home and sometimes people are admitted to hospital when it could have been completely avoided in the first place, if the right care were available in the community or in the person's home. Integrating health and social care and integrating primary, community and secondary care at local level, alongside improved commissioning will address these issues and keep people out of hospital and supported in their own homes where most people would rather be.

Existing services are mainly focused on treating ill health rather than supporting people to stay well. Patients and service users often feel disempowered by a system that deals with problems after they arise and would rather be supported to make their own choices about how services can help them to remain well and independent.

In West, North and East Cumbria, NHS organisations together with Cumbria County Council and the Community, Voluntary and Independent Sectors are committed to making changes that put Cumbria people at the centre of our health and social care services to deliver a system that:

- Works with individuals, families and communities to co-produce services
- Involves people in discussions and decisions about their care and places their views at the heart of decision making
- Helps people to make informed choices
- Supports and empowers people to remain healthy and independent
- Communicates well among all professionals involved in providing health and care services

2. Getting more from our existing resources

West, North and East Cumbria, like the rest of the UK, is seeing people live longer but this means that more people are living with multiple and complex health conditions. This presents challenges to health and social care services to change how they do things. Demand for services is increasing while budgets are falling.

So, we need to address a triple bottom line, improving outcomes for communities, building resilience among staff and managing increased demand with less money.

Nationally, 50% of all GP appointments and 70% of in-patient bed days are taken up with caring for people with long term conditions and locally a high proportion of the total health and social budgets is spent on looking after a small proportion of local people – often older people with the most complex needs and often in care settings rather than at home.

Many of the hospital stays currently taken up with caring for older people with long-term conditions could be avoided altogether if these people were better able to manage their health with the appropriate support. A review of UK hospitals found that generally 50-60% of hospital beds are occupied with patients that could be better cared for at home or in community settings. Locally the Oak Group audit of beds at North Cumbria University Hospitals Trust showed that 62% of beds were occupied by patients whose medical needs could be better managed elsewhere.

Our ambition is to become an exemplar of how services can be run in rural, coastal and smaller urban centres, bringing together health, care the third and community sectors and local people to co-design new models of service which;

- Reduce the need to attend or stay in hospital
- Reduce length of stay in hospital
- Free up GPs and the wider team to work proactively with individuals and communities.
- Reduce demand on hospitals, freeing them to focus on providing short episodes of high quality intensive support to those who really need it.
- Reduce the number of people living in residential and nursing homes
- Reduce the use of long term intensive packages of care
- Reduce rates of carer breakdown
- Create models of care and organisational structures which enable the health and care system to manage within available resources.

3. The System Needs to Change

For many years, health and social care professionals have been working more closely together but this has often taken occurred on a fragmented basis and for patients and

service users. The way our health and social care system has been set up has often hindered rather than helped professionals to provide joined up people centred care.

The Government has pledged to deliver integrated health and social care across England by 2018. We have made some in-roads with the Better Care Fund, for example funding a reablement service and testing out ways of supporting care homes and commissioning carers services and lessons from the BCF programme are being fed into the design of ICCs.

In the Five Year Forward View (2014), it was suggested that primary care of the future would need to build on the traditional strengths of 'expert generalists,' proactively targeting services at registered patients with complex on-going needs such as the frail elderly or those with chronic conditions, and working more intensively with these patients. To enable this way of working, leadership of primary care will need to include nurses, therapists and other community based professionals. It will need to offer care in fundamentally different ways, making fuller use of digital technologies, new skills and roles and offering greater convenience for patients.

It is the intention that ICCs will be the building block for future new organisational forms which will be determined in time via the Strategic and Transformational Plan process, on a form following function basis.

4. Integrated Care Communities (ICCs)

Based on natural communities of between 20,000 and 70,000 people, the ICCs will form an extended primary health and care team, where GPs, Social Workers, Nurses, Therapists, Support Workers and the Voluntary sector work together in teams to wrap themselves around individuals, families and communities, providing both person centred co-ordinated care and an organised approach to improving the population health.

They will have local budgets, enabling them to flexibly respond to local population need to deliver and arrange services. They will be able to draw on the range of services which are commissioned at a county or STP footprint level and on the existing frameworks for domiciliary, residential and other services. However, they will also have a key role in reducing dependence on such services and in working with commissioners to develop services to meet local needs.

Where services are of a more specialist nature or cover a wide geographical footprint, they will sit at a clinical network level, where the interactions with ICCs will be fundamental to the wider system efficacy. Provision such as specialist respiratory or heart failure or respiratory medicine will out-reach into the ICCs and ICCs teams will in-reach into acute settings to expedite discharge.

Interface with wider services and systems

We will achieve the best balance between local innovation and choice and the adoption of system wide pathways, the use of agreed specifications and frameworks for services. This

will enable local flexibility but will make use of the capacity achieved by working systems wide. In particular we will ensure that the local MDTs can interface in a tailored way with hospital discharge services and social care providers.

The ICCs aim to achieve the following outcomes for individuals, families and communities;

- Reductions in attendance and use of hospitals, reducing unplanned admissions, length of stay and movements across the system.
- Reductions in the use of residential and nursing care, aiming to reduce admissions and overall length of stay.
- Increases in people receiving rehabilitation and reablement at home to maximise independence.
- Increased numbers of people being able to die in their own home rather than in hospital.
- Increases in people being able to take control of their own health and care by use of expert patient programmes, digital access, telehealth and telecare.
- Increased engagement of local organisations such as schools, employers, third sector groups in promoting health choices and communities.

Models of Care

The ICCs will integrate community and primary health care and social care at the local level, organised around agreed populations and communities. They will also work with secondary care clinicians to ensure there are smooth pathways and that they can access specialist advice where needed.

ICCs will enable the development of a population based model of health and social care where an individual's wellbeing is maximised through communities, voluntary and statutory services working together to co-ordinate and deliver care with an integrated approach at a place based level. Multi professional teams will be at the core of the ICC.

Prevention and Self Help

Cumbria County Council is developing a new health and social wellbeing system which will work across the County, linking into the ICCs.

This has three main components;

1. A universal offer, building a digital platform for advice, signposting and self-help in managing healthy lifestyles, accessing local support such as for weight management or exercise and directing people to on line support from key partners such as Diabetes UK. We will also encourage people to make use of existing community assets such as sports facilities, libraries, clubs, societies, churches and village institutes.

2. A Managed Network of Third Sector and Community Groups providing support in areas such as Good Neighbour Schemes, advice and information, home from hospital and handyperson services. This will be brought together at a local level with NHS commissioned functions such as Expert Patient Services and Social Prescribing.
3. A Team of 30 Health and Well Being Coaches (HAWCs), who will be allocated across ICCs with fair shares allocated to WNE Cumbria. They will be targeted to support people who are deemed to be 'on the cusp' of entry into expensive health and care services and to provide direct support to help people build networks, reduce isolation and resolve issues which place them at risk.

In addition, the Council has located a Public Health Manager into each of the six Area Management Teams and they will be working strategically to help develop the concept of a 'fully engaged' community, engaging on needs, resource mapping and building Social Capital, drawing on County and District Council and NHS partners to build local capacity.

Co-ordinating Care for People who are using services

Currently people move around the health & social care system in an un-coordinated way, particularly patients who need to access urgent care, accessing services via different gateways, travelling along a variety of patient pathways and often having to navigate the best way around and ultimately out of the system themselves. The current structures support individual organisational needs and constraints above the need for services to wrap around the patient. A GP or a Social Worker may be seen as the co-ordinator of a person's care but they will not necessarily know that a person has been admitted to an acute setting, nor what the outcome of that acute intervention was. In West, North and East Cumbria, we need to support the needs of the person in the community that ensures a much better experience for that person and their family which in turn will result in less duplication for the ICC Teams and therefore increasing the amount of time to provide quality services to local people.

Our ICC vision can only be achieved by bringing together all community based services to provide proactive, joined up care working towards shared outcome goals. A one team approach. This is a shift to a new way of working. It will require a cultural leap in how different professions work together but also a fundamental change in the more practical aspects of work, such as IT systems. A key aspect of the ICC one team model is the empowerment of frontline staff to collaborate and innovate to provide the best care possible for the local population. For this reason there will be variability in the delivery of some services, but with the same outcomes delivered.

In the main however, ICCs will be structured and have defined components that will be uniform across all ICCs and they will work within system wide approaches where this makes most sense: The fundamental principle in delivery is that fully engaged informed individuals and carers work with health & care professionals committed to partnership working (this translates as integrated teams with the right culture and approach) to deliver person centred co-ordinated care with better outcomes.

- There will be a single management structure, led by an ICC Manager.
- There will be an aligned ICC budget for integrated provision of services, moving to an integrated budget when new organisational forms are in place.
- Services will be provided over a 24/7 timeframe.
- There will be an integrated community service that is made up of GPs, nurses, social work staff, therapists, home care practitioners and third sector representatives.
- There will be an ICC co-ordination hub that enables seamless transfer of information between the local ICC Team as well as health and social care staff that work at the clinical network level. It will act as the conduit between acute, community and primary care services as well as having access to timely data (acute in-patient data, GP clinical systems, social care data, community caseloads, risk stratification data, public health indicators, etc.). This will enable the ICC to gain a collective, shared viewpoint of their population's needs and use of services at any one time and will support them to provide a proactive, co-ordinated response to expedite discharge or prevent an unnecessary admission.
- Back office support may be shared across ICCs to enable economies of scale.

Support and Enablers

The ICCs will be supported by Systems wide approaches to IT, records management and information management.

There will also be a system wide implementation plan for support via digital systems covering the spectrum from digital/app based advice and self help, telecare, to support vulnerable people be safer at home and in the community, including people with physical frailty as well as those with Learning Disabilities and Dementia, telehealth and telemedicine to help people manage their own LTC, support reduced hospital admission and shared care arrangements and enable remote medicine, for example models similar to the remote fracture services provided at NCHUT.

The re-negotiation of contracts with care homes will build in a requirement to collaborate with ICCs on the use of telecare/telehealth and also to collaborate on how to meet local needs in a timely way.

The provision of domiciliary care will be organised to ensure that ICCs can build a relationship with local providers and work together to understand capacity and demand.

Processes

- There will be a multi-disciplinary management team that will meet on a regular basis that will include a professional lead from each discipline, i.e. ICC Manager, GP, Lead Nurse, Lead Therapist, Lead Social Worker, Public Health & Wellbeing Co-ordinator, Voluntary Sector Representative and Patient Representative.
- We recognise not all services will operate with critical mass at the ICC level, and therefore ICCs will benefit from access to strong and consistent integrated specialist services such as special rehabilitation, frailty units, rapid assessment clinics, specialist children's services and other consultant led services which will operate within a wider integrated clinical network. There will be clear links to specialist teams and functions that sit at the Clinical Network level.
- There will be a focussed approach to health promotion and self-management across the ICC population. There will be linked brokerage functions provided by Social Care to ensure packages and placements can be organised rapidly from framework providers and to support people who wish to have a direct payment. We will extend the function to manage health packages (such as Continuing Health Care) and health personal budgets.
- We will benchmark activity across ICCs and with national best practice in key areas to ensure they are contributing to closing the health gap and financial gaps and are meeting the aspirations of the health economies commissioning strategies.
- A joint approach to telecare and telemedicine and how it can help people live independently in their own homes.
- A systematic approach to care & support planning, care plans and management of the frail/elderly population.

Each ICC will have a set of defined functions or interventions:

- There will be regular multi-disciplinary team meetings, to discuss and share intelligence regarding the ICC population.
- Co-ordination Function. The ICC Hub will be the 'heartbeat' of each ICC. Shared information systems will ensure that each resident will receive more proactive person centred care. The Hub will know when a patient is in hospital and who their key worker is when they return home. Each cohort of patients depending on their needs will have different types of key workers. As interoperability increases, ICC hubs will be able to co-ordinate virtual outpatient consultations with acute consultants, reducing the need for either patient or consultant to travel unnecessary distances.
- A multi-agency co-ordinated Rapid Response function. To prevent inappropriate admission and enable discharge. The most appropriate team member will respond to keep someone safe. An Integrated Rehabilitation & reablement function will

maximise someone's independence with a recognition that the best place to do this is within someone's own home.

- End of Life Support, linking to specialist teams at Clinical Network Level.
- Care Co-ordinator function. Depending on a person's need, there will be a standardised approach to care co-ordination and care and support planning, including a personal care plan that is visible to all relevant providers of health & care.
- Standardised approach to pathways, e.g. frailty, respiratory, dementia
- Standardised approach to self-management, linking with local employees & educational establishments to ensure the same messages are heard at every level of the community.

Uniformity versus Variability

We expect all ICCs to be delivering the same outcomes but ICCs will vary in size and there will be freedom to provide services in a variable way. They will adhere to the same governance principles but will obviously take into account the local variances. We will aspire to the population as a whole having access to the same level of services as everyone else. ICCs will need to link closely to the functions provided at the Clinical Network level to ensure there is equity of provision relating to specialist services.

Future Ways of Working

As organisations, we're supporting staff to work together, bringing everyone together into a new team to remove valueless steps in the system:

- We are moving to a way of working that will be proactive, focussing on 'anticipatory care.'
- We will use risk stratification approaches to identify people who need specific support and to anticipate the needs of high risk people. This will enable the development of early intervention and contingency planning with people.
- The team will work together to solve the needs of individuals rather than referring to each other.
- There will be increased capacity to respond to need by reducing duplication.
- Shared Information. The ICC Hub will be able to track patients around the health and social care system, informing the ICC Team who in turn can help the ICC population navigate their way along the health and care pathways

5. What are we aiming to achieve?

We anticipate that the impact of ICCs will be to:

- Ensure that people are treated and supported at the right time and in the most appropriate setting.

- Ensure an increased focus on prevention, encouraging individuals and mobilising the population to take personal responsibility for their own health and wellbeing.
- Ensure an increased focus on prevention and greater use of community assets to support wider individual wellbeing.
- Focus more attention on self-care/support.
- Embed person centred care and shared decision making.
- Deliver more care outside of hospital.
- Ensure more care planning/risk stratification across the health and social care system.
- Improve quality through reduced clinical variation.
- Establish more **efficient** services with less waste.
- Deliver a positive patient experience that feels joined up and **seamless**.

By working seamlessly with strengthened ambulatory care, frailty services and rapid access clinics, we are seeking to achieve a reduction in admissions of frail elderly patients and reduce length of stay. Our initial estimates are that we will reduce admissions of frail elderly patients by up to 12% and reduce length of stay for the frail elderly in inpatient and community hospital beds by around 3 days on average. This equates to an overall reduction in bed usage of around 10%. However, based on evidence from the Millom (part of the Vanguard in South Cumbria), we believe that a 20% reduction in bed days could be achieved within 5 years. This is not necessarily the limit of our ambition but it's a good place to start.

We have developed a number of indicators which we will use to measure the impact of ICCs:

Outcomes	Measured By	Indicator
Improved patient/service user experience	Improvement in people's experience of receiving care Proportion of people dying in their place of choice Social Care Satisfaction Survey	Patient and carer experience feedback GP survey Locally defined ICC indicators tbc Practice data Advocacy and Healthwatch feedback.
Improved staff experience	Increased recruitment and retention rates Reduced staff sickness rates Improvement of staff experience of delivering care and support reported. Progression routes between roles.	Organisational data Organisational data Staff questionnaire
Improved outcomes Patient /service user supported to	Proportion of older people (65 and over) who were still at home 91	Adult Social Care Outcomes Framework

<p>maintain their independence in their place of choosing</p> <p>Patients/service users are supported to manage their long term condition</p>	<p>days after discharge from hospital into reablement/rehabilitation services</p> <p>Readmissions within 28 days for selected patient types</p> <p>Proportion of people feeling supported to manage their long term condition</p> <p>Proportion of Primary care Interventions to avoid unnecessary ambulance conveyances</p> <p>Improving one year cancer survival rates</p> <p>Reduction in potentially avoidable admissions for high risk groups</p>	<p>Inpatient Data</p> <p>GP survey data</p> <p>NWAS data</p> <p>NHS outcomes data</p> <p>Inpatient data</p>
<p>Healthier Communities</p> <p>Promotion of healthier behaviour</p>	<p>Improvement in the public health indices tables for the ICC population.</p> <p>Increased number of smoking quitters</p> <p>Increased number achieving weight management goals</p> <p>Increased number achieving physical activity goals</p> <p>Reduction in social isolation.</p> <p>Increase in numbers of people receiving support from community groups and social networks.</p>	<p>Public Health Data</p> <p>Acorn Data</p> <p>QOF data</p> <p>Acorn data</p> <p>Public health data.</p> <p>Public health data.</p>
<p>Better use of resource</p>	<p>Reduction in inappropriate emergency admissions</p> <p>Reduction in overall Delayed Transfers of Care across all hospital sites</p> <p>Reduction in admissions to residential & nursing home placements.</p> <p>Reduction in readmission rates</p> <p>Reduction in A&E attendances</p> <p>Reduction in unnecessary ambulance conveyances</p> <p>Reduction in bed days in both an acute & community hospital setting</p> <p>Reduced high intensity packages</p> <p>Increased take up of assistive technology</p>	<p>Inpatient data</p> <p>Inpatient data</p> <p>Inpatient data</p> <p>ASC/NHS dataset</p> <p>Inpatient data</p> <p>In patient data</p> <p>NWAS data</p> <p>Inpatient data</p> <p>ASC/NHS data.</p> <p>GP/ASC survey data</p>

6. Implementation Plan

We have confirmed that three ICCs will be mobilised in April 2016 (early adopters), with a further two in October 2016, with complete roll out by the end of 2016/17. The three early adopter sites proposed are Workington, Maryport & Cockermouth and Eden, two of which will also benefit from being part of the national Primary Care Home initiative.

The role of the early adopters will be fourfold:

- To start to integrate in “shadow form” before any major change programme is initiated reflecting a new employing organisation.
- To work together to find solutions to the enabling areas i.e. governance, financial delegation, information sharing, interoperability, estates, workforce, etc.
- To improve person centred care by developing new pathways, e.g. frailty pathway.
- To improve use of resources. ICCs will mean less duplication and increased shared understanding, pooling knowledge and resources.

A detailed implementation plan is under development and will be signed off by the Senior Responsible Officers.

7. Case Studies

MARJORIE (78)

What happens now?

Marjorie, age 78, gets admitted to hospital following fall at home. Marjorie has a care package in place to help with meals and getting up in the morning. On arrival at A&E Marjorie is slightly confused and disorientated; she is admitted to an elderly care ward. A Urinary Tract Infection (UTI) is identified and treated. Marjorie is reviewed by a Consultant Geriatrician and assessed as medically fit and ready to discharge as she has no acute medical needs. An OT assesses Marjorie and recommends care package review as she would benefit from additional personal care upon discharge. Marjorie remains in hospital awaiting social care re-assessment causing delay to discharge and deterioration in her mobility.

New ICC pathway

Marjorie, age 78, gets admitted to hospital following fall at home. Marjorie has a care package in place to help with meals and getting up in the morning. On arrival at A&E Marjorie is slightly confused and disorientated; she is admitted to an elderly care ward. A UTI is identified and treated. Marjorie is reviewed by Consultant Geriatrician and assessed as medically fit and ready to discharge as she has no acute medical needs.

Call made to ICC team to facilitate discharge. Team arrange for Marjorie to be met at home by our rapid response service. Following a review of her discharge support needs, a home care practitioner provides interim home care call in afternoon to support Marjorie with her evening meal preparation. The rapid response service provides additional support to Marjorie re falls prevention.

Marjorie has additional support for interim period and after 2 weeks has no further needs. No additional social care package required and has needs met in community resulting in prompt discharge – no DTOC. Care coordinator visits patient as part of discharge plan and links Marjorie to a local day centre to help with her mobility and social circumstances.

ANGELA

56 year old Angela lives at home with her daughter. She has multiple complex health issues, including asthma, hypothyroidism, peripheral neuropathy, depression, anxiety, psychosis, and she struggles with her weight. Angela's daughter works shifts, which means that Angela can often find herself home alone. Although her carers visit twice a day, Angela will only allow them to assist her with food preparation and resists allowing discussions about her personal care.

Angela has had frequent unscheduled hospital admissions which disrupted the delivery of her care. Unsure who to contact about specific healthcare issues, Angela, her daughter or neighbours phone 999 to access advice, support and services. As a result, Angela had several hospital admissions.

New ICC pathway

The ICC team has defined the patient groups who are likely to benefit most from proactive, integrated services through use of a population stratification tool. This list is combined with a 'real time' list of individuals identified by care practitioners from partner organisations using their professional, clinical and social care judgement to create an ICC 'at risk' list.

Angela is identified as being 'at risk' and a key worker is allocated to her to undertake initial assessment to establish her specific needs. A key worker links with Angela to discuss her personal care and mobility issues, while the team's nurse and linked social worker work together to review Angela's care package including a medicines review and an appraisal of any equipment which might help Angela. Angela is referred to the specialist respiratory team which works to help manage her respiratory condition and to the First Step service to offer support around her anxiety and depression. The ICC Team also considered support for Angela's daughter and arranged for the local Carer's Association to carry out a carer's assessment. The team works closely with the local pharmacy and it is agreed that her medication should be blister-packed to assist with the correct dosage and that rescue packs of steroids and antibiotics should be made available to her.

As a result of this integrated approach, Angela's understanding of her complex health issues improve. This reduces her levels of anxiety and stress, allowing her to manage her illness and agreed programme of care more effectively. Taking the correct analgesic medication her pain reduces to a manageable level. Angela also feels much more supported and involved in her own care. Instead of calling 999, Angela and her daughter have a list of key contacts she can call regarding a wide range of health issues and to access appropriate support services in the community. This support has alleviated her anxiety and increased her confidence in managing her illness. She allows care agency staff to help her with her personal care. Attendances at A&E and admissions reduce.

Angela's daughter has also benefited from the involvement of the ICC Team. She no longer has to take time off work and has confidence that her Mum has emergency numbers that she can contact for help and support.

BERNARD & EILEEN

The GP gets a request for a home visit. Bernard (76) has a chest infection but can't get to the surgery as he has limited mobility. The GP visits and discovers that Bernard is worrying about his wife, Eileen (78) for whom he has been caring. She is getting increasingly confused.

The GP contacts ICC hub coordinator who arranges for one of the ICC nurses to visit to assess both Bernard and Eileen. Eileen is referred to ICC mental health worker who arranges for a full assessment to confirm a dementia diagnosis. Eileen is referred to some daytime support sessions, which provides some respite for Bernard.

The nurse also refers the couple to the ICC care coordinator who links Bernard with West Cumbria Carers. Bernard is helped to claim benefits and starts to attend a Carer Support group while Eileen is at the daytime support sessions. The care coordinator also arranges for the community pharmacy to deliver medication.